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Family Problems in the Background of Mental Health Professionals

Linda Elaine McCarter
Eastern Illinois University

FAMILY PROBLEMS IN THE BACKGROUND

OF MENTAL HEALTH PROFESSIONALS

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LINDA ELAINE MCCARTER

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FAMILY PROBLEMS IN THE BACKGROUND OF MENTAL HEALTH PROFESSIONALS

by

Linda Elaine McCarter

Bachelor of Arts

Eastern Illinois University

1985

ABSTRACT OF A THESIS

Submitted in partial fulfillment of the the requirements for the degree of Master of Arts in Psychology in the Graduate School of Eastern Illinois University

Charleston, Illinois

1987

ABSTRACT

It has been proposed by some that students choose to study in mental health related fields in an effort to find solutions for their own personal emotional or family problems. Some believe that those who assumed or were assigned a family role of the good or parentified child (a role which requires that the needs of others be placed ahead of one's own) are over-represented among mental health professionals. Others contend that there are no significant differences in family background between psychotherapists and other individuals with a similar level of education. Little empirical investigation has addressed these issues. Studies which have been conducted have typically involved small samples without controls. Since therapists' personal issues may have a direct bearing on positive therapeutic outcome, it is important that research be undertaken to establish a baseline for the incidence of family problems among professionals in general against which psychotherapists may be compared.

The present study compared the family histories of a clinician group to a control group of university professors. The clinician group (n = 56) included staff members from three university counseling centers and six community mental health centers. The control professionals (n = 105) were all university instructors. All 161 subjects completed a questionnaire designed specifically for this study. The questionnaire used a 5 x 10 matrix with 5 types of family member (self, mother, father, sibling, and other) across the top of the matrix, and 10 types of problem down the side (school problems, substance abuse/addiction, mental health admission, stress related physical condition, mental diagnosis, victim of child abuse, victim of sibling abuse, victim of sexual abuse, victim of spouse abuse, and abuser of spouse or children.

Clinicians reported a significantly higher number of family problems than the nonclinician controls. A univariate comparison for each category of family member revealed a significantly higher number of problems in the clinician group for subjects' siblings and fathers, as well as for the subjects themselves. A univariate analysis comparing the incidence of each problem type between the two groups demonstrated that 3 of the 10 problem types had occurred significantly more often among the psychotherapist group than among the controls. These were school problems, substance abuse/addiction, and stress related physical illness.

A univariate cell by cell comparison for each of the 50 cells in the questionnaire matrix revealed significant differences in 10 of the cells. These were substance abuse/addiction by the subject, a sibling of the subject, and by an extended family member; mental health admission of the subject; the subject as a victim of child abuse; school problems of a sibling; stress related physical illness of a sibling and the subject's father; sibling as a victim of spouse abuse; and sibling as an abuser of spouse or child.

A significantly higher number of clinicians claimed earlier than average assumption of adult responsibility. No significant differences were found between the two groups in the incidence of suicide in the family, the number of subjects who were firstborn children, or the number of subjects whose parents had been divorced or separated before the subjects entered college.

Clinical implications as well as areas for further investigation were discussed.

DEDICATION

To people helpers everywhere -

May they learn to help others better

by learning more about themselves.

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INTRODUCTION

Whether psychotherapists are trained in psychiatry, psychiatric social work, or clinical or counseling psychology, they have been found to come from similar backgrounds, select similar experiences during their training periods, and ultimately provide similar services to their clients (Burton, 1971; Henry, Sims, & Spray, 1971). However, the personal experiences or characteristics which may lead to this career choice have received little attention. It is a common belief that those who choose professions in the mental health fields have experienced a higher than average incidence of difficulty in their own personal lives.

It has been proposed by some that students may choose study in mental health fields in an effort to find solutions for their own personal emotional or family problems (Burton, 1972, 1975; Ford, 1963; Goldklank, 1983; Harris, 1976; McCarter, 1985, 1986; Norwood, 1985; Querishi, Brennan, Kuchan & Sackett, 1974; Racusin, Abramowitz & Winter, 1981; Storr, 1980; Wegscheider, 1980). Some believe that those who assumed or were assigned a family role of good or parentified child (a role which requires placing the needs of others ahead of one's own) are over-represented among mental health professionals (Bergman, 1985; Boszormenyi-Nagy & Ulrich, 1981; Goldklank, 1983; Lackie, 1985; McCarter, 1985, 1986; Skynner, 1981; Wegscheider, 1980; Whitaker, 1981). Others contend that there are no differences in family background between psychotherapists and other individuals with a similar level of education (Henry, 1977; Henry, Sims & Spray, 1971, 1973; Roe, 1969). Little empirical investigation has addressed these issues. Studies which have been conducted have typically involved small samples without controls (e.g. Harris, 1976; Racusin, Abramowitz & Winter, 1981).

Several studies have supported the hypothesis that vocational choice in a field such a psychiatry, psychology or social work may be influenced by psychological difficulties in the personal life of the aspiring professional. Ford (1963) studied the autobiographies of 25 male psychiatric residents. With only one exception, these 25 residents agreed that they had been lead into psychiatry in response to a need within themselves, primarily a need for resolution of inner conflict. Taking into consideration the autobiographies of these 25 residents, as well as his personal knowledge of more than 50 other students who were personally known to him over a 15 year period, Ford concluded that psychotherapists may undertake training to work through and deal correctively with these early conflicts, and that some may require psychotherapy for "inherent ego defects" (Ford, 1963, p. 482).

Burton (1972, 1975) studied the history of 12 well known and successful psychotherapists. Based on the similarities he found among these therapists, he recommended 15 criteria for selecting candidates for healing work, stating that while their absence might not predict failure, their presence has been associated with success. Included in this list are a family background of "considerable disruption and upheaval", and personal experience of "depression, despair, and dissociation" (Burton, 1972, p. 315). He described what he termed "almost a silent conspiracy in the refusal to look at the treatment needs of the psychotherapist" (Burton, 1975, p. 115).

Harris (1976) examined the early background of a small sample of child therapists who had been identified by their colleagues as being effective therapists. Her subjects tended to be first or only children who saw their relationships with their parents in negative terms. She concluded that

childhood deprivations, in particular a lack of parental responsiveness, had facilitated the therapists' capacity for empathy.

Racusin, Abramowitz and Winter (1981) conducted intensive interviews of 14 psychotherapists. These interviews revealed physical and behavioral difficulties which involved presumed psychogenic factors in at least one member of each therapist's family. A high incidence of psychological problems was reported. In particular, alcoholism and child abuse constituted 12 of the 38 psychological problems reported. Almost three-fourths of these subjects reported themselves to have played a role in their own family of origin designed to fulfill the needs of others. Racusin, Abramowitz and Winter concluded that the early experiences of these therapists may have trained them for sensitivity to interpersonal stress.

In his writings concerning family experiences and family roles of social workers, Lackie (1985) stated that caretaking experiences in families of origin shape career choice and professional development. In his study of 1577 social workers, more than two-thirds described themselves as having been the over-responsible member, the mediator or go-between, the good child, or the burden bearer in their families of origin. It is Lackie's contention that many helping professionals "came from families that may have exploited (their) capacity for concern" (Lackie, 1985, p. 316).

In a study which investigated the belief that family therapists come from dysfunctional families and were over-responsible children, Goldklank (1983) looked for evidence of generational boundary crossing. Generational boundary crossing may be defined as performing functions or exhibiting behaviors more appropriate to another generation than the one to which an individual would logically be assigned. She found that family therapsts had enacted generational boundary crossing and high-esteem roles, in contrast to their siblings who had not crossed generational

boundaries and had filled lower or low-esteem roles. Professionals in the control group had not crossed generational boundaries, but had held high-esteem roles. Goldklank has shown that the therapists had crossed the boundary between their own generation and that of their parents, performing functions more appropriate to their parents than themselves, while their siblings and the control professionals had not crossed this boundary. Other authors who have commented on this tendency to assume or be assigned an over-responsible, parental role include Bergman (1985), Boszormenyi-Nagy and Ulrich (1981), Lackie (1985), Skynner (1981), Wegscheider (1980), and Whitaker and Keith (1981).

In a study of the characteristics of undergraduate majors in psychology, Querishi, Brennan, Kuchan & Sackett (1974) asked students to give their reason for majoring in psychology. Over half said they were attracted to the subject matter itself or sought personal gratification, as opposed to having made the choice as a result of vocational aims.

Henry, Sims and Spray (1971, 1973) conducted a study of the lives of approximately 4000 psychotherapists, with intensive interviews of a subsample of 300. They found nothing in the family experiences of their subjects which could account for choosing a mental health career. More specifically, they found "little in the personal backgrounds to suggest experiences leading to emotional distress, nothing to suggest major dissociative experiences, personal hostilities, or severe affective deprivations" (Henry, 1977, p. 55). However, they did advise caution in accepting this conclusion due to the absence of comparable data on other professional groups or on the general population. Roe (1969) examined motivational forces of psychotherapists and found them to

be basically indistinguishable from other persons with a graduate education and broad social interests.

A number of family therapists have observed what they see as a complementarity of sibling roles within the family, an observation which supports the contention that mental health professionals may have played an overadequate role in their families of origin. Bergman (1985) reports working with families in which one sibling is a certified psychotic and another a certified psychiatrist, psychologist, or social worker. In her book about alcoholic families, Wegscheider (1980) defined family heroes as individuals who develop more visible potential than their siblings, but who attain these achievements not to satisfy their own personal needs, but rather to compensate for deficits of self-worth in their parents or family. Norwood (1985) has observed that women from dysfunctional homes, especially alcoholic homes, are over-represented in the helping professions. Boszormenyi-Nagy & Ulrich (1981) have also discussed good or parentified siblings who sacrifice self strivings to preserve family balance.

In a discussion comparing sick and well siblings in inadequate families, Skynner (1981) suggested that siblings who appear well exhibit behaviors which are high in the hierarchy of family values, but limit personal growth. Since these well appearing siblings may be nonsymptomatic because they possess more rigid defenses, they might actually be less healthy than the identified patient. Skynner claims this is particularly common among mental health professionals. Whitaker & Keith (1981), in contrast with the proverbial black sheep, call this over-adequate or over-responsible family member the white knight. They describe the role as a socially overadapted hero who may be used to cover up family dysfunction and extol health. They believe this healthy appearing

member is usually pathological in the same way a psychotherapists is, that is, preoccupied with doing good, helping others, and liable to becoming a nonperson in the process.

If it appears that individuals with problematic backgrounds are over-represented among mental health professionals, this factor could have implications in the areas of candidate selection and training, as well as support and/or supervision issues for the practicing professional. Further, it would seem apparent that therapists' personal issues could have a direct impact on the quality of clinical services delivered to the client. With these considerations in mind, it is important to undertake research designed to establish a baseline for the incidence of family problems in the backgrounds of mental health professionals.

Two previous studies have attempted to address this issue. In 1985, McCarter conducted a survey using a simple yes and no questionnaire. This study compared the incidence of family problems in the backgrounds of 44 psychology students with the incidence of problems in the lives of 53 students from 21 other academic majors. Psychology students reported a significantly higher total number of problems. In addition, analysis of each individual problem type disclosed a significantly higher occurence of substance abuse, child abuse, and mental health admissions in the histories of the psychology students.

The 1985 study by McCarter was replicated and expanded using an improved questionnaire (McCarter, 1986). The Family Background Questionnaire (Form A) devised for the 1986 study contained a 54 cell problem by family member matrix. It was designed to ascertain which family members were most likely to have experienced problems as well as which problems were most likely

to have occurred. Backgrounds of 73 psychology students were compared with 101 students from 23 other majors. Once again a significantly higher incidence of family problems was reported by the psychology students.

Results showed that it was most likely to have been the mothers of the psychology students or the students themselves who had experienced difficulties. Consideration of different types of problems disclosed significantly higher incidences of substance abuse, child abuse and spouse abuse in the families of the psychology students. More specifically, the following combinations of family member and problem type were found to be more likely to have been present: fathers and other relatives such as grandparents, uncles or cousins who had abused or were addicted to drugs or alcohol, siblings who had been phsyically abused by their parents, and mothers who had been physically abused by their spouses and had stress related physical illnesses.

These two studies support the hypothesis that psychology students have experienced more family difficulties than their counterparts in other majors. It is not possible to infer from these results whether or not this same difference exists for practicing professionals. The present study was undertaken to address this question.

METHOD

Subjects

An experimental psychotherapist group was obtained by distributing questionnaires to the clinical staffs of six county mental health centers, three university counseling centers and the faculties in the Psychology and Educational Psychology Departments at Eastern Illinois University. Faculties from these departments were surveyed because some of the members also maintain a private practice or consult to local agencies. Questionnaires were also mailed to seven psychologists in private practice who were listed in the local telephone directory. A total of 56 respondents identified their area of primary interest as counseling or psychotherapy. Of these 56, 30 had doctorates, 22 had master's degrees, and 4 had bachelor's degrees.

The subject pool for the nonclinician control group was obtained by beginning with the first name on the 1541 member faculty and staff list for Eastern Illinois University, selecting every eighth name, beginning again with the third name on the list, and once again selecting every eighth name. This process produced a list of 308 names. From this list, names of 116 ancillary staff were eliminated, leaving a total of 192 faculty members. Questionnaires were distributed to each person on the 192 name list. Questionnaires were returned by 105 subjects who identified a primary area of interest which was other than counseling or psychotherapy. By education level, the control group was composed of 60 individuals with doctorates, 30 with master's degrees, and 15 with bachelor's degrees. Thus a total of 161 subjects returned questionnaires, 90 with doctorates, 52 with master's degrees, and 19 with bachelor's degrees.

Materials

Information was obtained via a revised form of the Family Background Questionnaire, a device which had been designed for use in an earlier survey of a similar nature (McCarter, 1986). (See Appendix A.) The questionnaire consisted of two basic parts. The first part was composed of questions concerning area of interest, education level, number of siblings, subject's position in the family birth order, whether or not the subject's parents were divorced or separated before the subject entered college, and whether or not early family circumstances caused the subjects to take on adult responsibilities earlier than their peers.

The second part of the questionnaire consisted of a 5 x 11 cell matrix with 5 types of family member across the top of the matrix and 11 types of problem down the side. The 5 family members were: 1) self, 2) mother, 3) father, 4) sibling, and 5) other. The 11 problem types were: 1) problems in school, 2) drug/alcohol abuse/addiction, 3) mental health admission, 4) stress related physical condition, 5) mental health diagnosis, 6) victim of physical abuse by parent, 7) victim of physical abuse by sibling, 8) victim of sexual abuse, 9) victim of physical abuse by spouse, 10) abuser of spouse or children, and 11) suicide. Since it is impossible for the subject himself to have committed suicide, this resulted in a missing cell in the last row of the matrix. Therefore, the suicide question was evaluated in a separate analysis. This left a 50 cell family member by problem matrix available for analysis.

Procedure

Presentation of the questionnaire varied among the different types of subjects. Questionnaires to the Eastern faculty and counseling center staff were distributed through campus mail. Each questionnaire was accompanied by a brief explanatory letter which stated that the research was being conducted to examine the prevalence of family difficulty in the backgrounds of college-educated individuals. (See Appendix B.) An enclosed, self-addressed return envelope allowed the participants to return their completed questionnaires by campus mail. Questionnaires were mailed to the seven private practitioners by regular postal service.

To the eight other mental health and counseling centers, questionnaires were distributed by a collaborator who was a member of each agency staff. These subjects were given the same letter that subjects in the control group received. They were told that the purpose of the study was to examine the incidence of family problems in the background of college-educated individuals, advised that participation was voluntary, given envelopes in which to seal their completed questionnaires to protect their anonymity, and instructed to place these sealed envelopes in the message box of the collaborating staff member. This staff member in turn submitted the questionnaires, still sealed in their envelopes, to the experimenter. To further protect anonymity, questionnaires from all nine agencies and institutions were combined before the envelopes were opened.

RESULTS

An analysis of variance with two levels of area of interest (clinician and non-clinician) and three levels of education (bachelor's, master's and doctorate) and with unequal cell size was computed. Clinicians were found to have reported a significantly higher number of family problems than the non-clinician controls, F (1,155) = 13.285, $p < .001$. Significant differences were also found in the number of problems reported by the three education levels, F (2, 155) = 3.227, $p < .05$, with M.A. subjects showing the highest group mean. No significant interaction was obtained. (See Table 1 for a summary of the results of this analysis.) An analysis of variance comparing the number of problems reported by families of varying sibling size showed significant differences, F (2, 149) = 3.402, $p < .01$, with families with six or more siblings having the greatest number of problems.

The number of problems was tabulated for each of the five types of family member (self, mother, father, sibling, and other) and a discriminant analysis performed. A significant discriminant function was found, $p < .01$, df = 5, canonical correlation = .31, Wilks lambda = .901. A univariate comparison for each category of family member revealed a significantly higher number of problems in the clinician group for siblings, fathers, and for the subjects themselves. (Figures from this analysis are reported in Table 2.)

When the number of problems reported was distributed over the 10 problem types, the discriminant analysis was significant, $p < .001$, df = 10, canonical correlation = .38, Wilks lambda = .855. Univariate analysis demonstrated that 3 of the 10 problem types occurred significantly more often among the psychotherapist group than among the controls. These were school problems, substance abuse and stress related physical illness. Victim of sexual

abuse was significant at the .10 level. (See Table 3 for complete figures from this analysis.)

A discriminant analysis was computed comparing clinicians with controls on numbers of problems checked in each of the 50 possible combinations of family member and problem type. This analysis yielded significant results, $p < .05$, df = 44, canonical correlation = .60, Wilks lambda = .636. A univariate cell by cell comparison revealed that 10 of the 50 cells showed significant differences between psychotherapist and control groups. These were substance abuse by self, mental health admission of self, substance abuse by sibling, school problems of sibling, stress related physical illness of sibling, sibling physically abused by spouse, sibling who abused spouse or child, mental health admission of father, stress related physical illness of father, and substance abuse by other family member. (See Table 4.) Six other cells—self as a victim of sexual abuse, stress related physical illness of mother, mental health diagnosis of mother, sexual abuse of mother, mental health admission of father, and stress related physical illness of other family member—were significant at the .10 level. In all comparisons that were significant, clinicians reported more problems than controls. (See Table 5 for percentages of each group which responded positively to each cell.)

No significant differences were found between the two groups in the incidence of suicide in the family, the number of subjects who were firstborn children, or the number of subjects whose parents had been divorced or separated before the subject entered college. A significant difference was found at the .10 level between the two groups in the number of subjects who claimed earlier than average assumption of adult responsibility ($p = .0679$).

TABLE 1

MEAN NUMBER OF PROBLEMS REPORTED BY CLINICIANS AND NON-CLINICIANS

	N	M	SD
Clincians			
Ph.D.	30	3.533	2.933
M.A.	22	5.818	5.151
B.A.	4	3.000	2.160
Total	56	4.393	
Controls			
Ph.D.	60	2.167	2.478
M.A.	30	2.867	2.700
B.A.	15	2.200	2.396
Total	105	2.371	
Entire Sample	161	3.075	3.268

TABLE 2

UNIVARIATE ANALYSIS OF DISTRIBUTION OF PROBLEMS BY FAMILY MEMBER (df = 1,159)

	Clinical Mean	Nonclinical Mean	Total Mean	Value of F
Self	.71429	.36190	.48447	6.457*
Mother	.73214	.49524	.57764	1.543
Father	.76786	.42857	.54658	5.585*
Sibling	1.01786	.47619	.66460	11.270**
Other	.89286	.54286	.66460	2.510

* $p < .05$

** $p < .001$

TABLE 3

UNIVARIATE ANALYSIS OF DISTRIBUTION OF PROBLEMS BY PROBLEM TYPE (df = 1, 153)

	Clincical Mean	Nonclinical Mean	Total X	Value of F
School Problem	.69643	.44762	.53416	4.395*
Drugs/Alcohol	.75000	.30476	.45963	13.91**
Mental Admission	.32143	.21905	.25466	1.378
Stress Illness	1.19643	.65714	.84472	11.69**
Mental Diagnosis	.35714	.22857	.27329	2.569
Abused by Parent	.33929	.16190	.22360	2.443
Abused by Sibling	.01786	.02857	.02484	.113
Sexually Abused	.17857	.07619	.11180	3.105
Abused by Spouse	.10714	.10476	.10559	.106
Spouse/Child Abuser	.16071	.07619	.10559	2.448

* $p < .05$

** $p < .001$

TABLE 4

SIGNIFICANT FINDINGS OF UNIVARIATE ANALYSIS OF FAMILY MEMBER/PROBLEM TYPE COMBINATIONS BETWEEN CLINICIANS AND NONCLINICIANS (df = 1,159)

	F	p
Self		
Substance abuse	4.334	<.05
Mental health admission	5.870	<.05
Victim of child abuse	4.398	<.05
Sibling		
Substance abuse	9.687	<.01
School problems	7.331	<.01
Stress related physical illness	4.931	<.05
Victim of spouse abuse	3.841	<.05
Abuser of spouse or child	5.870	<.05
Father		
Stress related physical illness	5.937	<.05
Other		
Substance abuse	6.020	<.05

TABLE 5

PERCENTAGE OF CLINICIANS AND NONCLINICIANS WHO REPORTED EACH FAMILY MEMBER/PROBLEM COMBINATION

Note: Percentages for clinicians appear in upper lefthand corner of each cell; percentages for nonclinicians in lower righthand corner.

	Self	Mother	Father	Sibling	Other
School Problem	10.7 / 6.7	1.8 / 3.8	1.8 / 4.8	46.4 / 25.7	8.9 / 3.8
Substance Abuse	10.7 / 2.9	5.4 / 2.9	17.9 / 11.4	16.1 / 2.9	25.0 / 10.5
Mental Admit	5.4 / 0.0	8.9 / 6.7	8.9 / 2.9	3.6 / 3.8	5.4 / 8.6
Stress Illness	19.6 / 16.2	32.1 / 19.0	32.1 / 15.2	17.9 / 6.7	17.9 / 8.6
Mental Diagnosis	0.0 / 0.0	8.9 / 6.7	8.9 / 2.9	1.8 / 3.8	16.1 / 9.5
Child Abuse	12.5 / 3.8	3.6 / 1.9	3.6 / 1.9	7.1 / 3.8	7.1 / 4.8
Sibling Abuse	0.0 / 1.0	1.8 / 0.0	0.0 / 0.0	0.0 / 1.0	0.0 / 1.0
Sexual Abuse	10.7 / 3.8	5.4 / 1.0	0.0 / 0.0	0.0 / 0.0	1.8 / 2.9
Spouse Abuse	1.8 / 1.0	1.8 / 3.8	0.0 / 2.9	3.6 / 0.0	3.6 / 2.9
Abused Spouse or Child	0.0 / 1.0	3.6 / 3.8	3.6 / 1.0	5.4 / 0.0	3.6 / 1.9

DISCUSSION

The results of this study demonstrate a significantly higher incidence of problems in the family histories of clinicians than in the histories of control subjects regardless of level of college degree. Examination of the distribution of the types of problems experienced reveals that the problems which differentiate between the two groups are school problems, substance abuse or addiction, and stress related physical illness. This supports the findings of McCarter's 1985 study, which showed significant differences in substance abuse, child abuse, and mental health admissions. It also supports her 1986 study, which showed significant differences in substance abuse, child abuse, and spouse abuse. Racusin, Abramowitz and Winter (1981) also found significant amounts of alcoholism and child abuse in the histories of their subjects.

The results of this study show that the clinicians were over three times more likely to have abused drugs or alcohol than their counterparts in the control group. The clinicians' siblings were over five times more likely to have abused a substance than the siblings of control subjects. The psychology students in the 1985 study by McCarter reported a substance abuse problem over four times more often than their control counterparts. Subjects in the 1986 McCarter study reported the existence of substance abuse in their families over five times more often than control students. In the case of these student subjects, the substance abusers were not the subjects themselves, but the fathers and extended family members.

It is possible that the significant differences between clinicians and non-clinician controls could be attributable to a greater willingness on the part of the clinicians to admit to problems of this type. Another possibility could be a heightened sensitivity on the part of the clinicians to recognize and identify such difficulties. However, it is felt that these factors alone could not have

resulted in such a substantial and highly significant difference. In all comparisons of clinicians and non-clinicians that were significant, clinicians had reported more problems than non-clinicians.

Additionally, when the reported problems were tabulated for the five family member types (self, mother, father, sibling, and other), there was a significantly higher number of problems reported for three of the four possible family members in the clinicians' immediate families (self, father, and sibling). In contrast, a significant difference was not found between the two groups in the numbers of problems reported for extended family members. This lends support to the belief that unwillingness or inability to report did not play a major role in obtained differences between groups. Had greater willigness or heightened sensitivity on the part of the clinician subjects been a significant confounding factor, it stands to reason that this effect would have applied not only to immediate family members, but would have carried over to reported problems of extended family members as well.

Similar results were found in the univariate analysis of each matrix cell. Of the 10 cells which revealed significant differences between the two groups, 3 of them applied to the subjects themselves, 5 to siblings of the subjects, and 1 to fathers of the subjects. Thus there were a total of 9 positive cells out of the 40 possible ones (almost 25%) which pertained to immediate family members. On the other hand, only 1 of the 10 possible problem categories (10%) reached significance for the extended family. This nonsignificant difference in the number of problems reported in the extended family again appears to support acceptance of the significant differences between the two groups as valid.

A review of the univariate analysis of the distribution of problems over the five types of family member revealed significant differences for the subjects themselves, as well as their fathers. Highly significant differences were found for the subjects' siblings. This result provides support for the hypothesis that therapists may be more likely to have played the "white knight" or more responsible role (e.g., Whitaker & Keith, 1981) in their families of origin.

It should be noted, however, that there were also significant differences between the two groups reported by the subjects about themselves. Specifically, examination of the results of the cell-by-cell comparison revealed that the members of the clinician group were more likely to have been victims of physical abuse as children, to have had mental health admissions, and to have themselves abused or been addicted to drugs or alcohol.

It is of interest to note that responses to the item on the questionnaire which inquired if the subjects had been compelled to assume responsibilities earlier than their peers were significantly related to whether or not they were clinicians ($p = .0679$). In a similar survey (McCarter, 1986) comparing psychology students with control subjects from other majors, this question resulted in a highly significant difference between the two groups ($p < .001$).

Implications

There are a number of implications of this study which may be related to positions taken by other theoretical and data based studies. These include therapists' family of origin roles, personality development of therapists, the value of therapy for therapists in practice and in training, and the potential effect of the therapist's psychological health on the client's therapeutic outcome.

Family Roles

The findings of Lackie (1985); Racusin, Abramowitz, and Winter (1981); Harris (1986); and McCarter (1985, 1986); as well as the findings of the present study, support the belief that an individual with certain type of background is over-represented among mental health professionals. This individual has been variously described as a "parentified" or "good" child (Boszormenyi-Nagy & Ulrich, 1981), an "over-responsible" child (Racusin, Abramowitz & Winter, 1981), a "well" sibling (Skynner, 1981), a "white knight" (Whitaker & Keith, 1981), a "hero" (Wegscheider, 1980), and a "burden bearer" (Lackie, 1985). It appears that all of these terms refer to the same type of individual.

Boszormenyi-Nagy and Ulrich (1981) have defined this parentified child as "the 'good sibling' who sacrifices self-striving so as to preserve the family balance" (Boszormenyi-Nagy & Ulrich, 1981, p. 169). Overly responsible children who attempt to save or rescue their families do so at the risk of their own personal growth and well-being (Racusin, Abramowitz & Winter, 1981; Skynner, 1981; Wegscheider, 1980; Whitaker & Keith, 1981). Their resultant low self-esteem is caused by a failure to master the impossible task of parenting their parents, who are the overt authority figures in the family. These individuals may adaptively undertake a profession of helping others in order to replace the impossible task of healing their own families, and may thus enhance their self-esteem (Lackie, 1985). Because "good" children turn to sources outside their families for the overt recognition and validation that their covert roles within the family do not allow, they are likely to be high achievers (Lackie, 1985).

Families which function at a suboptimal level may express intimacy in modes which preclude a mutual or reciprocal expression of feeling (Racusin, Abramowitz & Winter, 1981). In such a setting, the empathy of the

parentified child for others takes precedence over empathy for the self. Psychotherapy as a profession may appeal to such individuals because the therapeutic relationship is a similarly nonreciprocal relationship, but this time with the therapist in the more powerful position. Thus the decision to become a therapist may represent a desire to experience emotional intimacy in a safe environment over which the therapist maintains control (Racusin, Abramowitz & Winter, 1981). In training, it is important to heighten candidates' awareness to the part their pasts may have played in their career choice, as well as how their past experiences may affect their professional functioning, so that they can learn to accept their "less-than-perfect, but good-enough self" (Lackie, 1985, p. 319).

Therapist Personality

Since therapy is an interaction between two personalities, it is important to consider the personality of the therapist. Storr (1980), in a chapter devoted exclusively to this topic, described a number of therapist personality characteristics which enhance the probability of a positive therapeutic outcome. Each of these characteristics could develop as a result of being raised in circumstances such as those described above.

One such feature is an openness to emotional experience. Psychotherapy is a counter-cultural experience. Thoughts and feelings which would be suppressed or forbidden in a social setting are encouraged in a therapeutic one. It could be that individuals choose psychotherapy as a career because the daily intimate expereinces may compensate for emotional deprivation in their early lives (Racusin, Abramawtiz & Winter, 1981).

Another quality of a good therapist as described by Storr (1980) is the ability to be affected by the emotions of others without acting on one's own

feelings, never fully expressing one's own personality, but always remaining oriented to the needs of others. It would seem apparent that the early life experience of a parentified child could serve as a good training ground for the development of such characteristics.

Storr (1980) also discussed the ability to be open both to the emotions of others and of oneself, as well as a tendency to put the needs of others ahead of oneself, as valuable traits for a good psychotherapist. He suggested that this tendency toward emotional openness and self-abnegation may be traced to the therapists' childhoods, which may have required or enabled them to develop an awareness of the feelings of others with a concommitant inhibition of free expression of their own needs and demands.

Lastly, Storr (1980) suggested that successful psychotherapists possess "an especial capacity for identifying with the insulted and injured" (Storr, 1980, p. 173). Storr (1980) and others (e.g., Harris, 1986; Lackie, 1985; Racusin, Abramowitz & Winter, 1981) have posited that a therapist's knowledge of how it feels to be injured may in some way enhance the evolution of a more extended range of compassion than might otherwise have been possible.

Therapy for Therapists

A number of authors have supported therapy for the therapist as at least a useful, and sometimes necessary contributor to a psychotherapist's effectiveness (Bowen, 1978; Burton, 1972, 1975; Ford, 1963; Guerin & Fogarty, 1972; Lackie, 1985; Storr, 1980). Burton (1972, 1975) contended that psychotherapy cannot be truly successful unless the "growing edge" of the therapist is fostered in the therapist's work. He recommended what he called an annual satisfaction check-up for therapists.

In support not only of therapy for therapists in general, but family therapy in particular, Lackie (1985) proposed that the old adage to "know thyself" be extended to read "know they family". Storr (1980) pointed out that doctors are better doctors if at some time they have had to be patients. In consideration of the observations of these authors, as well as the results obtained in this study, it seems reasonable to conclude that therapists might improve the delivery of their services if they were provided an opportunity to experience therapy themselves.

Therapeutic Outcome

A number of authors have made statements regarding the contribution of the history and current psychological state of the therapist to a positive therapeutic outcome (Bergman, 1981; Bowen, 1978; Burton, 1972, 1975; Coleman, 1985; Ford, 1963; Guerin & Fogarty, 1972; Lackie, 1985; Neill & Kniskern, 1982; Skynner, 1981; Storr, 1980; Whitaker & Keith, 1981). Whitaker and Keith claimed that where therapists are in their own growth intermeshes with the help they provide their clients. They contended that the client in therapy cannot progress beyond the level of development or well-being of the therapist providing the therapy. Whitaker is a particularly staunch supporter of the concept of putting oneself first in the interest of being more available and more useful to one's clients. He has been quoted as saying: "Question: Whom to trust? Answer: The man who openly loves himself more than he does you" (Neill & Kniskern, 1982, p. 371).

Lackie (1985) suggested that therapists who have established a balanced position on the omnipotence/helplessness continuum are less likely to view clients as either good or bad, a view which can be countertherapeutic. He cautioned that optimal caretaking involves responsibilities not only to others,

but also to oneself, a fact which some helpers are prone to forget. Storr proposed that "perhaps one can fully understand only those aspects of personality in others of which one can find traces in oneself" (Storr, 1980, p. 169-170).

Skynner (1981) claimed that the therapist's psychological health is the most crucial therapist attribute. He related that therapeutic techniques he used quite effectively at one time in his life lost their therapeutic efficacy over a period of time and use. He speculated that this decrease in efficacy may have resulted from the fact that he had resolved whatever personal need of his own had rendered those techniques useful or meaningful for him.

Bergman (1985) also reported that his clinical areas of interest have paralleled the developmental stages in his personal life. For example, he reported that as he became less concerned and invested with the cruelty and anger in his own family, he became less invested in working with the cruelty and anger which keeps some resistant families resistant. And when he became less somatically oriented and less hypochondriacal himself, he became less interested in his research on autonomic responses.

Framo (1981) cautioned that it is as unwise to appear ideal as it is to overburden the client with the personal problems of the therapist. While therapists who are overwhelmed by their own emotional problems cannot function adequately as therapists, those who believe they have no problems at all may be equally unsuitable. None of this is to say that the wrong people become therapists, but rather that their motivations for doing so should be recognized and thoroughly dealt with by both trainers and trainees. Because the clinicians report more problems does not necessarily mean that they are less effective. Burton (1972) and Racusin, Abramowitz and Winter (1981) have

even gone so far as to suggest that a problematic history in an applicant may signify a promising candidate.

It may be correct that history and psychological well-being of therapists affects their potential for being successful therapists. The statements of Bergman (1985), Framo (1981), Lackie (1985), Neill and Kniskern (1982), Skynner (1981), and Whitaker and Keith (1981) lend support to this idea. Given the probable importance of the therapist's psychological health in relation to positive therapeutic outcome, and the implications of the results of this study, it seems even more important that therapists who have problematic histories consider therapy for themselves to correct deficiencies that might interfere with their effectiveness.

Summary

The results of this study represent a contribution to a slowly growing body of research which supports the hypothesis that individuals with traumatic early histories are over-represented among the mental health professions. It might seem strange that the literature of disciplines which so frequently draw attention to dysfunctional groups exhibits so little published material covering therapists' families of origin. Lackie (1985) offers one possible explanation. He contends that for psychotherapists to publish ideas about their professions is tantamount to good children exposing the secrets of their professional families.

Therapists may have more to gain than to lose from overtly acknowledging the facts of their less than ideal family backgrounds. While the therapists' illusions concerning their own superiority may have to come to an end, corresponding increases in personal understanding, autonomy, and professional insight may be the beneficial results.

The ability to cope with one's own problematic background, rather than be overwhelmed by it, or at it's mercy, may make an adequate therapist. Good therapists go beyond coping, to a point where their knowledge of themselves can become a therapeutic instrument available for use in the service of their clients. As Storr (1980) has said, understanding other human beings requires that observers make use of their understanding of themselves. Thus the more therapists understand themselves, the better they will understand their clients. Conversely, the more they understand their clients, the better they will understand themselves.

Good mental health is not the absence of any or all problems, but rather the ability to foster personal growth, to change and adapt creatively to an everchanging environment. It is this author's hope that psychotherapists will accept the challange to admit that they do therapy for their own satisfaction and personal growth, as well as for the benefit of their clients, and that one way to foster their own personal growth is to examine the motivating factors which lead them to choose a career in a mental health field.

This research has generated more questions than it has answered. One question is: Does an individual who has experienced the kind of background discussed here make a more empathic or effective therapist than one who was raised in a less problematic environment? Another point to consider is the fact that most of the subject clinicians in the present study were practitioners in an agency setting. It is not known whether or not the findings obtained here generalize to private practitioners, or whether they are specific to therapists who prefer to work in agencies. The possibility that therapist candidates may have been reared in dysfunctional families raises a number of questions concerning the best ways to select and train these candidates. A

much closer look at this entire area is needed, for the issues raised strike at the very heart of the therapeutic relationship.

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APPENDIX A

FAMILY BACKGROUND QUESTIONNAIRE

What is your highest earned degree? Doctorate_____ Master's_____ Bachelor's_____

What is your primary area of interest?
Teaching____ Administration____ Counseling or psychotherapy____ Other____

How many brothers and sisters were born into your family? _____

What is your place in the birth order of your family? (1st, 2nd, 3rd, etc.) _____

Were your parents divorced or separated before you entered college? Yes____ No____

Do you think that your early family circumstances required you to take on adult responsibilities at an earlier age than your friends?____Yes ____Not sure ____No

Has anyone in your family ever . . . . . (Check all that apply)

	Self	Mother	Father	Sibling	Other*
Had problems in school?					
Abused or been addicted to drugs or alcohol?					
Had a mental health admission?					
Had a stress-related physical condition**					
Been diagnosed to have a mental illness?					
Been a victim of physical abuse by a parent?					
Been a victim of physical abuse by a sibling?					
Been a victim of sexual abuse?					
Been a victim of physical abuse by a spouse?					
Physically abused spouse or children?					
Committed suicide?					

*Grandparent, cousin, aunt or uncle
**e.g. ulcers, high blood pressure, etc.

(Form B)

APPENDIX B

Psychology Department
Spring, 1987

Dear Prospective Participant:

Please take a minute to complete the enclosed anonymous questionnaire and return it in the self-addressed envelope provided for this purpose. You will be making a valuable contribution to my research concerning the prevalence of family difficulty in the backgrounds of college-educated individuals. No previous large scale quantitative studies have ever addressed this question.

Your cooperation is greatly appreciated.

Sincerely,

Linda E. McCarter